BUREAU OF FACILITY STANDARDS – Department of Health and Welfare
P.O. Box 83720, Boise, Idaho 83720-0036 (208) 334-6626

APPLICATION FOR NURSING FACILITY LICENSE AND ANNUAL REPORT 2004

NOTE: Information provided on this form, such as facility name, address, and number of licensed beds, should match our **current** records **exactly**. If you need to make a change in these fields, please attach a separate letter outlining the change.

Nursing Facility Name: _____

Address: _____
Street Address and number or RFD

_____ , Idaho _____ _____
City Zip County

Telephone No.: (208) _____ Fax Number: (208) _____

Facility's E-Mail Address: _____

I. REPORTING PERIOD.

The twelve-month period of **October 1, 2003**, through **September 30, 2004**, should be used for comparison and trend analysis purposes.

___ Yes, the facility was in operation for twelve full months as of **September 30, 2004**; the required reporting period was used.

___ No, the facility was <u>not</u> in operation for twelve full months as of **September 30, 2004**; an alternate reporting period was used.

Reporting Period Used: _____ No. of Days in Reporting Period: _____

II. CLASSIFICATION – Ownership

A. Check the entity which has legal responsibility for operation of the facility.

_____ State or local government _____ Non-profit owner

_____ Federal government _____ For-profit owner

B. Are you:

_____ Free-standing _____ Hospital-based

III. BEDS

A. Current Bed Capacity

Total licensed beds _____ _____

Beds equipped for use _____ _____

B. Bed Capacity Change

B.1. Has the licensed bed capacity changed during the reporting period?

___ No. ___ Yes. If yes, on what date (s) did the number change? _____

Previous licensed bed capacity _____ _____

B.2. Has the number of beds equipped for use changed during the reporting period?

___ No. ___ Yes. If yes, on what date (s) did the number change? _____

Previous number of beds equipped for use _____ _____

IV. OCCUPANCY RESIDENT MIX

During the reporting period, what was the total number of:

Medicaid inpatient days of care _____ _____

Medicare inpatient days of care _____ _____

Private inpatient days of care _____ _____

Veterans Administration inpatient days of care _____ _____

Other inpatient days of care (specify) _____ _____

_____ _____ _____

_____ _____ _____

Total number of inpatient days of care _____ _____

V. CNA TRAINING

Is Nurse Aide Training (NATCEP) being conducted in your facility by your staff or any other entity? Yes ____ No ____

VI. FISCAL YEAR

What is the facility's Fiscal Year Ending Date? _____ _____

VII. FISCAL INTERMEDIARY

Who is the facility's current Fiscal Intermediary (Part A Medicare Contractor)? _____ _____

_____

IF THERE ARE QUESTIONS ABOUT INFORMATION IN THIS REPORT, WHO SHOULD BE CONTACTED?

Name: _____

Title: _____

Telephone: _____

I CERTIFY THAT THE STATEMENTS MADE IN THIS REPORT ARE TRUE, COMPLETE, AND CORRECT TO THE BEST OF MY KNOWLEDGE

Signature of Administrator: _____

Date: _____

Visit us on the web at http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3350/DesktopDefault.aspx